NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Department of Services ● Department of Regulation and Licensure
Department of Finance and Support

Dear Applicant:

Thank you for your interest in becoming licensed to practice medicine and surgery in the State of Nebraska. Prior to submitting your application for licensure, it is important that you be aware of certain aspects of the application process.

The application form includes a series of questions about an applicant's history regarding licensure, physical and mental health, criminal conduct, and malpractice. I encourage you to read these questions carefully. It is expected that applicants answer these questions completely and truthfully. If others are assisting you in the completion of your application, make sure to review the information completely before signing the application. An adverse event in your past is not an automatic disqualification from licensure. The Board will review all of the information surrounding the event in making a determination of your fitness to practice medicine and surgery.

It is important that you fully disclose all arrests, charges or convictions. A question on the application asks not only about charges or complaints filed against you by any licensing or disciplinary authority, but it also asks for charges or complaints filed against you by any criminal prosecution authority. Even if the charges were dropped, dismissed, pled down or settled through diversion or if the sentencing was deferred or the conviction was expunged, set aside or pardoned, you must provide this information on the application. Failure to fully disclose could be considered as misrepresentation on your application which is grounds to deny your application for licensure.

Applicants are asked whether you have ever been convicted of a misdemeanor or felony. Some offenses that most people would consider as minor violations are actually misdemeanors, so it is important that you thoroughly review your history in order to provide accurate information regarding convictions. You may want to contact the court or seek the advice of an attorney to determine whether an event in your past resulted in a misdemeanor or felony conviction.

Applicants are asked whether you have ever been notified of any malpractice claim against you. This request includes all claims ever filed against you regardless of when they occurred or whether they were paid, settled or dropped.

Applicants should also be aware that it is the policy of the Credentialing Division that applications may not be withdrawn to avoid or circumvent a denial decision or to circumvent public records and reporting requirements. Understand prior to submitting your application that you may not be allowed to withdraw. Applicants who do not meet the requirements for licensure will be denied.

Thank you for taking the time to read this letter. I hope my comments are helpful to you. If you have further questions regarding the application process, please contact me by e-mail at becky.wisell@hhss.ne.gov or by telephone at 402/471-2118.

Sincerely,

Becky Wisell

Becky Wisell, Section Administrator
Medical and Specialized Health Section
Credentialing Division

GENERAL INSTRUCTIONS FOR LICENSURE IN MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY

REV. 7/06

OPTIONS FOR LICENSURE

Applications for **Licensure by Examination** are based on: United States Medical Licensing Examination (USMLE), National Boards of Medical Examiners (NBME), National Boards of Osteopathic Medical Examiners (NBOME), Federation Licensing Examination (FLEX), or Licentiate of the Medical Council of Canada (LMCC). A passing score must be achieved within four attempts on each part. All parts must be passed within seven years of passing the first examination (applicants who have been enrolled in a combined MD/PHD degree program in an accredited college of medicine must pass all parts within ten years). You must request that official documentation of passing scores obtained on all parts of the national examination you took be sent directly from the official repository of scores to this office. Following is a list of the official repository for scores for all of the accepted examinations, including phone number and website:

USMLE and FLEX contact FSMB at (817) 868-4041 website at www.fsmb.org
NBME (215) 590-9700 website at https://external1.nbme.org/ciw2/prod/jsp/login.jsp
NBOME (773) 714-0622 website at www.nbome.org
LMCC (613) 521-6012

Applications for **Licensure by Reciprocity** are most often based on a State Board Examination. These individuals must also meet all other requirements for licensure by examination. The Board of Medicine and Surgery will review the requirements under which you were licensed in the other state for comparability with Nebraska requirements. Please have the state in which you took the Board examination forward your scores and the requirements in effect at the time of your licensure to this office.

REQUIREMENTS FOR APPLICANTS

1. US and Canadian Medical School Graduates. **A certified final transcript** sent directly from the medical school is the only acceptable document to verify your completion of medical school. Substitutions, such as letters from the Registrar are **NOT** acceptable.

2. Applicants who graduate from an accredited United States school or college of medicine must have completed one year of postgraduate education in the United States or Canada. You **must** use the enclosed Certificate of Post-Graduate Medical Education Form.

3. Foreign Medical School Graduates: You **must** use the enclosed Verification of Foreign Medical College form to verify your medical school. Please have your medical school complete the form and send it directly to this office.

4. Applicants who graduate from a foreign school or college of medicine must have completed three years of postgraduate education in the United States or Canada. You **must** use the enclosed Certificate of Post-Graduate Medical Education Form.

5. Foreign graduates must possess a permanent Educational Commission on Foreign Medical Graduates (ECFMG) Certificate that is Valid Indefinitely. You must request that an official verification of ECFMG certification status be sent directly to this office from ECFMG (215) 386-5900 and the website is www.ECFMG.org. Fifth Pathway is also accepted and will require appropriate documentation.

6. A photocopy of an active Federal DEA Certificate must be sent with the application if controlled substances will be prescribed, administered or dispensed by the licensee.

7. Professional activities must be listed since graduating from medical college. Also, please list all periods of non-professional activity. This information is to be completed on the application form. **PLEASE DO NOT PROVIDE CURRICULUM VITAE.**

8. REGULATORY INFORMATION: If you answered "Yes" to any question(s) on pages 4-5 of the application (#1-17) you will be required to provide additional information regarding the circumstances and outcomes. All previous malpractice claims need to be reported. Please refer to page 5 of the application for specific information regarding the documentation required.

9. List **ALL** states where you have ever held an active or inactive medical license to include: locum tenens, temporary medical license, and/or permanent medical license. **You will need to have each state where you have ever held a license send a certification of licensure to this office.**

10. Present proof that, within the three years immediately preceding this application for license, you meet one of the following criteria:
    a. Have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year;
    b. Have had at least one year of approved graduate medical education;
    c. Have completed at least 75 hours of continuing education in medicine and surgery approved by the Board;
    d. Have completed a refresher course in medicine and surgery approved by the Board;
    e. Have completed the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards.

    See application for required documentation.

FEES

The expiration date for **ALL** Physicians and Osteopathic Physicians is October 1st of each even –numbered year. Determine the month and year in which you are submitting your application. Pay the amount in the corresponding box.

Year	Jan	Feb	Mar	Apr*	May	June	July	Aug	Sep	Oct	Nov	Dec
Even	$201	$201	$51	$51	$51	$51	$51	$51	$202	$202	$202	$202
Odd	$202	$202	$202	$202	$202	$202	$202	$202	$201	$201	$201	$201

Please call if you have questions. Your check will be returned if it is not the correct amount.
The ADDITIONAL FEE OF $1.00 OR $2.00 is for funding of a Licensee Assistance Program, which provides for a program to assist licensees in obtaining treatment for abusing alcohol and/or drugs.
*When a license will expire within 180 days after its initial issuance date the initial licensure fee is ¼ of the full fee. The full renewal fee will be due by October 1. You may request that your license be issued after October 1 by contacting our office.

WITHDRAWAL/DENIAL OF APPLICATION

Once an application has been completed with all the required documents submitted, the applicant will not be allowed to withdraw their application. If the applicant does not meet the requirements for licensure, a denial will be issued.

LICENSURE TIMELINE

Only completed applications will be considered for licensure. Please allow a minimum of 45-60 days after the completed application has been received in our office for the application process to be completed. The Department has up to 150 days to act upon any completed application.

LICENSE RENEWAL

The period for biennial renewal of medical licenses in the State of Nebraska is October 1st of even-numbered years. Renewal notices are mailed at least 30 days prior to the expiration date of your license. **It is your responsibility to keep this office advised of your current address so that correspondence will reach you.**

CRIMINAL BACKGROUND CHECKS
Instructions

LB 306 was passed by the 2005 Nebraska Legislature. This law goes into effect September 4, 2005, and will be codified as Neb. Rev. Stat. §71-104.01.

> An applicant for an initial license to practice a profession which is authorized to prescribe controlled substances as determined by the department shall be subject to a criminal background check. The applicant shall submit with the application a full set of fingerprints which shall be forwarded to the Nebraska State Patrol to be submitted to the Federal Bureau of Investigation for a national criminal history record information check. The applicant shall authorize release of the results of the national criminal history record information check to the department. The applicant shall pay the actual cost of the fingerprinting and criminal background check. This section shall not apply to dentists who are applicants for temporary practice rights (locum tenens) under subdivision (5) of section 71-183.01 or to physicians and surgeons who are applicants for temporary practice rights (locum tenens) under subdivision (17) of section 71-1,103.

To avoid delays in processing your application for licensure, fingerprints should be obtained and submitted to the Nebraska State Patrol at the same time as you submit your application for licensure to the Department.

Fingerprinting Procedure

1. **If you received a printed application from our office,** two fingerprint cards were enclosed. Take the fingerprint cards to any State Patrol office or law enforcement agency. Contact information for the Nebraska State Patrol offices is included with these instructions. No appointment is necessary for the Lincoln location. The Lincoln location is open Monday through Friday, 8 a.m. to 4 p.m. for fingerprinting. You must call ahead to schedule an appointment at the Nebraska State Patrol offices located outside of Lincoln to ensure that someone will be there to conduct the fingerprinting. These offices have limited hours when fingerprinting will be conducted.

2. The Nebraska State Patrol does not charge for the service of taking your fingerprints. However, other law enforcement agencies in Nebraska or other states may charge a fee.

3. **If you obtained your application online,** fingerprint cards can be obtained by contacting our office or from any State Patrol office or law enforcement agency.

4. **DO NOT FOLD THE FINGERPRINT CARDS.**

5. You must take one form of photo ID with you when obtaining your fingerprints. Acceptable forms of ID include a driver's license, visa or passport. If you are from a foreign country and do not have one of these forms of photo identification, provide any documentation issued by your country, legal sovereign or consulate.

6. You may print your name, address, Social Security Number, date and place of birth, and physical identifiers on the fingerprint cards. **DO NOT sign the fingerprint cards** until the law enforcement officer has verified your signature with the form of identification that you provide. **DO NOT write in the field labeled ORI.** In the space on the fingerprint cards marked "Reason Fingerprinted", you should print the following: "**R & L Health Credentialing**".

7. After the fingerprinting procedure is completed, the cards will be given to you. **DO NOT FOLD THE FINGERPRINT CARDS.** Place the cards in the envelope provided (if you obtained the cards from us), along with a personal check, money order or cashier's check for the appropriate fee listed below, payable to the Nebraska State Patrol, and drop it in the mail. If you obtained the cards from a State Patrol office or other law enforcement agency, you will need to place the cards and the payment in an envelope addressed to:

Nebraska State Patrol
CID Division
P.O. Box 94907
Lincoln, NE 68509

Fees

Fingerprints submitted on or after June 1, 2006, must include payment of $38.00.

8. It may take several weeks for your criminal background check to be received by the Department. No licensing decision will be made until all information is received.

Offices of the Nebraska State Patrol	Days/Hours that Fingerprinting is Conducted
Troop A 4411 S. 108th St. Omaha, NE 68137 Phone: 402/595-2410	Wednesday mornings from 8:00 a.m. to noon (appointment required)
Troop B 1401 Eisenhower Ave. Norfolk, NE 68701 Phone: 402/370-3456	Usually on Tuesdays (appointment required)
Troop C 3431 Potash Grand Island, NE 68802 Phone: 308/385-6000	Mondays from 10:00 a.m. to noon and from 1:00 p.m. to 2:45 p.m. (appointment required)
Troop D 300 West South River Road North Platte, NE 69101 Phone: 308/535-8265 ext. 219	Monday, Tuesday, Thursday, Friday from 8:30 a.m. to 5:00 p.m. Wednesday from 8:30 a.m. to 2:30 p.m. (appointment required)
Troop E 4500 Avenue I Scottsbluff, NE 69361 Phone: 308/632-1211	Wednesdays after 1:00 p.m. (appointment required)
Criminal Identification Division (CID) 233 S. 10th St. Lincoln, NE 68508	Monday through Friday 8:00 a.m. to 4:00 p.m. (no appointment necessary)

Deadlines For Receipt of
Licensure Applications and Supporting Documents

For applications for a license to practice medicine & surgery, osteopathic medicine & surgery and temporary educational permits.

Following are the deadlines for receipt of licensure applications and supporting documents for applications required to be reviewed by the Board of Medicine and Surgery. Some applications will require review by the Board of Medicine and Surgery at their regular meeting. These deadlines will apply if the Department determines that your application will need Board review. Please submit your application according to this schedule, assuming that your application will be reviewed by the Board. If your application does not need Board review, you will receive a license document in the mail.

1) APPLICATION DEADLINE DATE	2) DOCUMENTS DEADLINE DATE	3) MEETING DATE
April 30, 2006	June 9, 2006	June 30, 2006
June 11, 2006	July 21, 2006	August 11, 2006
July 22, 2006	September 1, 2006	September 22, 2006
September 3, 2006	October 13, 2006	November 3, 2006
October 15, 2006	November 22, 2006	December 15, 2006

1) **Application deadline:** The completed application form and check/money order must be received in our office by this date. Late applications WILL BE referred to the next application deadline.

2) **Documents deadline:** All supporting documents and additional information that our office requests must be received in our office by this date. Late submissions will cause your application to be reviewed at the next meeting date.

3) **Dates of the regular meetings of the Nebraska Board of Medicine & Surgery.**

This form may be completed online, printed and mailed to the address listed below.

Nebraska Department of Health and Human Services
Regulation and Licensure
Credentialing Division
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

Licensure Fees:

Please see cover letter for correct fee.
Please write check to: Nebraska Credentialing Division.

REV. 4/05

APPLICATION FOR LICENSE TO PRACTICE

(check appropriate category)

	MEDICINE AND SURGERY		OSTEOPATHIC MEDICINE AND SURGERY
APPLYING FOR LICENSURE BY EXAMINATION: (check appropriate item)			
	UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)		
	NATIONAL BOARDS OF MEDICAL EXAMINERS (N.B.M.E.)		
	NATIONAL BOARDS OF OSTEOPATHIC MEDICAL EXAMINERS (N.B.O.M.E.)		
	FLEX ENDORSEMENT (took and passed FLEX exam in state of _____)		
	LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (L.M.C.C.)		
	COMBINATION OF USMLE AND FLEX		
	COMBINATION OF USMLE AND NATIONAL BOARD		
APPLYING FOR LICENSURE BY RECIPROCITY:			
	RECIPROCITY BY STATE EXAMINATION (Passed State exam in the State of _____)		
Reciprocity candidates must meet all the requirements for licensure by examination, except instead of a national examination, these candidates may have taken a State Board Examination.			

Legal Name	Last:	First:	Middle:	Maiden:
Date of Birth (MO/DAY/YR)		Place of Birth (City/State/Country)		
Social Security Number:				
Telephone: (optional)		FAX: (optional)		
E-Mail Address (optional)				
Address (Dr. office or residence)	Street/PO/Route:			
	City:	State:	Zip:	

INDICATE THE DATE YOU SENT IN YOUR FINGERPRINT CARDS TO THE NE STATE PATROL _____

Have you ever sought or been granted medical licensure under another name? ***(answer yes or no)***	
If yes, indicate other name(s) used:	
Have you ever held a license in any health profession in the State of Nebraska? (physical therapy, nursing, **temporary education permit**, etc.) ***(answer yes or no)***	
If yes, please explain:	
Have you ever held a license in any jurisdiction in a health profession other than medicine and surgery? ***(answer yes or no)***	
If yes, please explain:	

PRELIMINARY AND PRE-MEDICAL EDUCATION	
Give name and location of institutions attended, beginning with high school, listing diplomas or certificates and date received for preliminary and pre-medical education.	
Institution:	
City/State/Country:	
Diploma/Certificate:	
Date: (MO/YR)	
Institution:	
City/State/Country:	
Diploma/Certificate:	
Date: (MO/YR)	
Institution:	
City/State/Country:	
Diploma/Certificate:	
Date: (MO/YR)	

MEDICAL EDUCATION I have spent _____ years in the study of medicine in the institution(s) listed below:			
Name of Institution			
City/State/Country			
Attended From	(M/D/Y)	To	(M/D/Y)
Degree Conferred (MD, DO, MBBS, etc)			
Name of Institution			
City/State/Country			
Attended From	(M/D/Y)	To	(M/D/Y)
Degree Conferred (MD, DO, MBBS, etc)			
You must request that official documentation showing successful completion of an accredited school or college of medicine be sent directly to the Department from the institution. This must indicate the degree you received and the date it was conferred. Documents not written in English must be accompanied by an official English translation.			
FOREIGN MEDICAL GRADUATES			
Foreign medical graduates MUST have ECFMG send an official verification of their **permanent ECFMG Certificate that is valid indefinitely** directly to our office (the ECFMG phone number is 215-386-5900 and the website is www.ECFMG.org). **My ECFMG number is: _____**			

POST-GRADUATE MEDICAL EDUCATION Indicate whether service was Internship, Residency or Fellowship.	
Name of Institution	
Name of Internship/ Residency/Fellowship	
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Internship/ Residency/Fellowship	
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Internship/ Residency/Fellowship	
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
You must request that official documentation showing successful completion of postgraduate medical education be sent directly to the Department from the program. A Certificate of Post-Graduate Medical Education form must be completed by the Program Director. The form is attached to this application packet. United States graduates must show successful completion of at least one year of postgraduate medical education in the U.S. or Canada. Foreign graduates must show at least three years of postgraduate medical education in the U.S. or Canada or approved graduate medical education. Documents not written in English must be accompanied by an official English translation.	

LICENSURE IN OTHER STATES			
Have you ever been granted medical licensure by any State or Territory? ***(answer yes or no)***			
If yes, list all current and non-current licenses below:			
You must request a Verification of Licensure or Letter of Good Standing from each State Medical and Osteopathic Board from each location where you hold or have held a license to practice medicine and surgery, a temporary education permit and/or a locum tenens. This document must be sent directly to our office.			
State or Territory	License Number	Effective Date	Expiration Date

MAINTENANCE OF COMPETENCY	
Nebraska statute requires that you present proof that, **within the three years immediately preceding this application for licensure**, you meet *one of the following criteria*. Check the criteria which applies to you:	
☐	I have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one **year within the three years immediately preceding this application**. *List this information in the section of this application marked "Professional Activities".*
☐	I have had at least one year of approved graduate medical **education within the three years immediately preceding this application.** *List this information in the section of this application marked "Post-Graduate Medical Education".*
☐	I have completed at least 75 hours of Category I Continuing Education as approved by the ACCME or AOA in medicine and surgery **within the three years immediately preceding this application.** *Submit* proof of attendance at continuing education, as well as information about the content for Board approval.
☐	I have completed a refresher course in medicine and surgery **within the three years immediately preceding this application.** *Submit proof of attendance at a refresher course, as well as information about the content for Board approval. This information can be a course brochure, a course syllabus or other official documentation.*
☐	I have completed the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards (FSMB) on the following date _____. *Have your SPEX score sent directly to this office from the FSMB.*

PROFESSIONAL ACTIVITIES – List in chronological order **all activities since graduation, including absences from work, except for incidental sick leave and usual vacation.** Also list all periods of non-professional activity or employment for more than three months. Please account for all time if engaged in private practice and explain all gaps in activity. Use additional page(s) if necessary.

From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			
From: Month/Year		To: Month/Year	
Name of Facility:			
City/State/Country:			
Activity:			

CONTROLLED SUBSTANCES REGISTRATION

A separate Nebraska Controlled Substances Registration is not required upon providing proof of a Federal Controlled Substances Registration (DEA number) to this office. Check one of the following:

☐	I have enclosed a photocopy of my current Federal Controlled Substances Registration. My Federal Controlled Substances Registration Number is ____________________________, and it expires on ________________.
☐	I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.
☐	I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time I am also to supply a photocopy of the registration to the State of Nebraska.

REGULATORY INFORMATION		
If you answer YES to any of the following questions, explain the circumstances and outcomes on the back of this application. **You must sign and date any additional pages that you attach to the application. Please read the information at the end of this section regarding the malpractice and misdemeanor/felony conviction information that is required.**		
1	Has any State or Territory of the U.S. ever taken any of the following actions against your license? ***(answer each yes or no)***	
	Denied	
	Revoked	
	Suspended	
	Limited	
	If yes, explain circumstances and outcomes.	
2	Has any licensing or disciplinary authority ever taken any of the following actions against your license? ***(answer each yes or no)***	
	Limited	
	Restricted	
	Suspended	
	Revoked	
3	Has any licensing or disciplinary authority placed your license on probation? ***(answer yes or no)***	
4	Have you ever voluntarily surrendered a license issued to you by a licensing or disciplinary authority? ***(answer yes or no)***	
5	Have you ever voluntarily limited in any way a license issued to you by a licensing or disciplinary authority? ***(answer yes or no)***	

6	Have you ever been requested to appear before any licensing agency? ***(answer yes or no)***	
7	Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary authority or criminal prosecution authority? ***(answer yes or no)***	
8	Are you aware of any pending disciplinary actions against your license in any jurisdiction? ***(answer yes or no)***	
9	Are you aware of any on-going investigations of a disciplinary complaint against your license in any jurisdiction? ***(answer yes or no)***	
10	Have you ever been addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence: ***(answer yes or no)***	
11	During the past ten years, have you voluntarily entered or been involuntarily admitted to an institution or health care facility for treatment of a mental or emotional disorder/condition? ***(answer yes or no)***	
12	During the last ten years, have you been diagnosed with or treated for bipolar disorder, schizophrenia, or any psychotic disorder? ***(answer yes or no)***	

13	Have you ever been convicted of a felony*? ***(answer yes or no)***	
14	Have you ever been convicted of a misdemeanor*? ***(answer yes or no)***	
15	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or State controlled substances registration? ***(answer yes or no)***	
16	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances? ***(answer yes or no)***	
17	Have you ever surrendered your State or Federal controlled substances registration? ***(answer yes or no)***	
18	Have you ever had your State or Federal controlled substances registration restricted in any way? ***(answer yes or no)***	
19	Have you ever been notified of any malpractice claim against you **? ***(answer yes or no)***	

All applicants must complete the following:		
Effective July 1, 2004, the Department is authorized to assess an administrative penalty in the amount of $10 per day, not to exceed a total of $1,000 when evidence exists that a person has practiced medicine and surgery prior to being issued a license or permit.		
20	Have you practiced medicine and surgery in Nebraska prior to issuance of a Nebraska Permit or License? ***(answer yes or no)***	
	If yes, how many days have you practiced medicine and surgery in Nebraska prior to issuance of a Nebraska Permit or License?	Total Number of ***DAYS***
Students of medicine and surgery enrolled in an accredited college of medicine who gratuitously practice medicine and surgery under the supervision of a licensed physician are exempt from needing a Permit or License in the State of Nebraska, pursuant to Neb. Rev. Stat. 71-1, 103 (4). Once an individual has graduated from medical school, however, a Permit or License is required in the State of Nebraska in order to practice medicine and surgery. The question above, therefore, refers to the time since you have graduated from medical school until such time as you have received a Permit or License to practice medicine and surgery in the State of Nebraska.		

**** Required Misdemeanor/Felony Conviction Information** If you have had any misdemeanor or felony convictions you must submit:	
1	Official Court Record, which includes charges and disposition;
2	Copies of Arrest records;
3	A letter from the applicant explaining the nature of the conviction;
4	All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
5	A letter from the probation officer addressing probationary conditions and current status, if the petitioner is currently on probation.

*** Required Malpractice Information** Regarding your malpractice, claim(s), **please include the following information. Sign and date your explanation**.	
A	State the **total number of claims ever filed against you;** *and*
B	Submit a **detailed explanation** (see below) of each claim ever filed against you. Do *not* send copies of forms completed for insurance companies or other entities.
C	For any malpractice claims that are **currently pending**, submit copies of the court documents that outline the statement of charges (often called the "Complaint") and a letter from the attorney stating the current status of the claim.
Include the following information regarding each claim:	
1	Name, sex and age of patient;
2	Date of occurrence;
3	Initial event (procedure/diagnosis);
4	Subsequent event that precipitated the claim – include the time sequence in relation to the initial event;
5	Damages – a description of damages or alleged damages resulting from the initial and subsequent events;
6	Date of filing of malpractice claim in court (if applicable);
7	Outcome of claim – include the court disposition, whether or not the case was settled, and **the amount of any monetary settlement or judgement made on your behalf. If no money was paid on your behalf, you must indicate this**.
8	Date of final outcome of claim.

AFFIDAVIT

I, _____, depose and say that I am the person referred to in the foregoing application and supporting documents and that I am of good moral character. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein and all supporting documents are true and correct to the best of my knowledge. I further solemnly swear upon my honor that if granted a license to practice Medicine and Surgery within the State of Nebraska, that I shall abide by the laws of Nebraska.

Signature of Applicant _____ Date _____
(M/D/Y)

State of _____)
)
County of _____)

In _____ (city) in said county on this _____ day of _____, 20_____,

_____ personally appeared before me, and being duly

sworn, deposes and says that he/she has carefully and truthfully completed this application.

(SEAL)

_____
Notary Public

My Commission Expires _____
Month/Day/Year

Please use the space below to provide additional information for any of the questions included in this application. If necessary, attach additional pages and sign and date each page.

Signature

Date

State of Nebraska
Department of Health and Human Services
Credentialing Division
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. Please mail the form directly to the address printed above.

Print Name _____SS# _____

NOTE: The information below must be completed ONLY by an official of the program/facility.
NOT TO BE COMPLETED BY APPLICANT

It is hereby certified that: _____
(Name of Applicant)

Has successfully completed _____
(Name of Residency/Internship/Fellowship)

located at : _____in_____
(Name of Hospital/Teaching Institution) (City, State, Country)

From _____ To _____
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

_____ ACGME* or AOA* accredited
_____ RCPSC* or CFPC* accredited
_____ was not accredited by any of the above listed entities

*ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association
*RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

Any Disciplinary Action? Yes _____ No _____ If yes, provide details of the disciplinary action.

Any Derogatory Information on File? Yes _____ No_____ If yes, provide details of the derogatory information.

Signature _____
Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name_____

Title _____

Date (month/day/year) _____

Phone # _____

Fax # _____

E-mail _____

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

FOREIGN MEDICAL GRADUATES:

IN ORDER TO EXPEDITE THE DIRECT SOURCE VERIFICATION OF YOUR MEDICAL SCHOOL DEGREE, YOU NEED TO COMPLETE THE TOP PORTION OF THE ATTACHED FORM, ATTACH A PASSPORT SIZE PHOTOGRAPH OF YOURSELF IN THE BOTTOM PORTION OF THE FORM AND SEND THE FORM TO YOUR MEDICAL SCHOOL. THE MEDICAL SCHOOL WILL NEED TO COMPLETE THE LOWER PORTION OF THE FORM AND SEND THE FORM DIRECTLY TO OUR OFFICE.

SUBSTITUTIONS FOR THIS FORM WILL NOT BE ACCEPTED. PHOTOGRAPH MUST BE INCLUDED AND VERIFIED BY SCHOOL.

THIS FORM IS FOR FOREIGN MEDICAL GRADUATES ONLY. Graduates of US or Canadian schools, please have your school send a certified final transcript or letter indicating date graduated and degree received.

State of Nebraska Department of Health and Human Services
Regulation and Licensure Credentialing Division
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

VERIFICATION OF FOREIGN MEDICAL COLLEGE

_____
Name of University

_____
Street

_____
City State Zip

I, _____, MD/DO have applied for a license to practice in the State of
(Print full name)
Nebraska. As part of the application process, the State of Nebraska requires a verification of my Foreign Medical College.

I hereby authorize _____, its staff or representative to provide the State of
(Name of College)
Nebraska any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the State of Nebraska. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____ Date of Birth ___/___/___
(Signature of Applicant) MO DAY YEAR

Social Security Number _____ Date of Graduation _____/_____/_____
MO DAY YEAR

For verification of FOREIGN MEDICAL COLLEGE ONLY. Please provide exact dates. The following section must be completed by the dean or registrar of the foreign medical school and returned directly to the State of Nebraska. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____
(full name of applicant)

Enrolled in _____
(Name of Foreign Medical College)

on _____/_____/_____ graduated _____/_____/_____
MO DAY YEAR MO DAY YEAR

and received the **DEGREE** of _____

Any disciplinary action on file? Yes (please explain)_____ No _____

Further, the records of this institution indicate that the attached photograph
(check one) _____ Represents a true likeness of the above named applicant
_____Does not represent a true likeness of the above-named applicant.

By _____ SEAL Attach
Original Signature of the dean or registrar Passport size
(stamped or electronic signatures will NOT be accepted) Photograph Here

_____
Print or Type Official's Name and Title

_____
e-mail address if possible

Signed and the college Seal affixed on ___/___/____ Medical College seal MUST be imprinted partially on photograph
MO Day Year